Governor's Workforce Investment Board
Health Care Task Force

Red Lion Colonial Inn, Helena
September 13, 2006

MINUTES

Committee Members Present: Karen Sullivan, Chair; Beverly Barnhart; Deb Matteucci, Scot Mitchell; LeeAnna Muzquiz, MD; Wendy Palmer; and Cindy Stergar.

Committee Members Absent: Lisa Addington; Mike Downing, DDS; Keith Kelly; and Pat Wise.

Staff: Emily Lipp Sirota; Leisa Smith; Chris Wilhelm; and Mary Eve Pietrukowicz.

Guests: Ingrid Childress; Brad Eldredge; Dave Gibson; Linda Hyman; Kristin Juliar; Mary Kelly-Clark; and Tyler Turner.

Welcome and Introductions
Chair Karen Sullivan called the meeting to order at 9:11 a.m. and welcomed members and guests. Task Force members introduced themselves. Marilyn Kelly-Clark, with the Business Standards Division, Health care Licensing Office, sat at the table representing Lisa Addington. Leisa Smith thanked members for all the important, highly valued work they have been accomplishing in such a short time. She reminded the Task Force members of the Governor's charges to the SWIB and SWIB Chairman Dan Miles's charges to the Health Care Task Force which are as follows:

1. Identify shortages and the regions within which they exist;
2. Identify causes of shortages;
3. Suggest remedies to identified shortages, and make recommendations on priorities and the best places to target resources.

Roll Call, Housekeeping and New Documents
Chris Wilhelm conducted roll call and discussed the SWIB website's new appearance, recently converted to the Governor's "common look and feel". The site's new address is www.swib.mt.gov, and SWIB staff will be maintaining it from now on. She stated the newsletter has been revised to a bi-monthly publication. She then reviewed members' packets, containing documents requested at the last Task Force meeting and provided by members. Chair Sullivan suggested relaxing the formal *Robert's Rules of Order* to encourage open discussion, and invited the public to comment at appropriate times. Cindy Stergar motioned to relax the *Rules*, and Scot Mitchell seconded. The members agreed by consensus.

Approval of Agenda
Members approved the agenda by consensus.

Approval of Meeting Minutes

Ms. Smith announced SWIB staff overlooked publicly noticing the July 19, 2006 meeting minutes, so they could not be formally voted upon as an action item at the meeting. Chair Sullivan offered an opportunity for comment to Task Force members and the public, and pointed out members will be able to approve the minutes at the upcoming conference call.

Information Items and Final Data Review

Research & Analysis

Dr. Eldridge reviewed his article, *Health care in Montana: In Short Supply?* written as a result of his research into the supply of a variety of health care professionals across the state. Members discussed his findings. Chair Sullivan asked Dr. Eldridge how he arrived at his conclusions that Montana does not appear to have a shorter supply of health professionals compared with the nation, with the exceptions of Medical Assistants, Physical Therapy Assistants, and Medical and Clinical Laboratory Technicians, who have location quotients below 0.8. Dr. Eldredge replied "shortage" is defined relative to national comparisons. Montana may be facing future shortages, or pockets of shortages, as the state's population continues to age.

Montana Hospital Association

Chair Sullivan stated Roberta Yager was not present to explain these data. Ms. Smith reviewed Ms. Yager's handout, *MHA Workforce Staffing Survey-Vacancy and Turnover*, for the years 2003, 2005, 2006, pointing out data collection has changed during this period. The survey was sent to all hospitals and nursing homes, representing a mix of small/large, rural/urban facilities. Participants for each year were listed on the last several pages of the handout.

Licensing

Marilyn Kelly-Clark discussed the *County and Licensing Report*, which represented Dental Hygienists, Clinical Laboratory Scientists and Physician Assistants. She will get data on dentists and physicians. Two issues with these licensees-by-county data are:

1. mailing addresses are used rather than work addresses; and
2. not all licensees are currently working in health care.

Ms. Kelly-Clark will be implementing a voluntary survey regarding scope of practice among all nursing professionals. Dr. Eldredge stated UI records are being matched with the licensing data. A voluntary survey would be helpful. Ms. Kelly-Clark stated pay is an important issue among nurses, for instance, she has two vacancies she has been trying to fill for months. Ms. Palmer said Clinical Laboratory Scientists can keep a license in inactive status; Ms. Kelly-Clark said this is also true for pharmacist licensees.

Montana Nurses' Association

Ms. Smith reviewed the two *Health Related Job Orders* spreadsheets presenting minimum salary data by job title.

Apprenticeship Program

In Mark Maki's stead, Ms. Wilhelm reviewed the *Federally Apprentice-able Trades Not Currently Utilized in Montana* and *High Growth Industry Profile* handouts. This is an issue under consideration with the SWIB Apprenticeship Committee, as well. Ms. Wilhelm stated the two reasons such trades are not being utilized by the state are:

1. lack of employers to participate; and
2. strict state licensing requirements.

Of the 25 "hot" careers identified by the U.S. Department of Labor, Pharmacy Technician, Level III, is the only one currently being apprenticed in Montana. Ten others are apprentice-able, and only one of these, Certified Nurses' Aides, is health-related. New apprentice-able trades must be registered with the state. Ms. Stergar stated Dental and Medical Assistant programs are not being apprenticed, but there is on the job training in these two areas. Ms. Smith cautioned that on-the-job-training may not have the same consistencies as a registered apprenticeship and training program.

Governor's Office

Ms. Lipp Sirota discussed the handout of recommendations from a previous governor's *Blue Ribbon Task Force on Health Care Workforce Shortages* and a 2005 review of *Follow Up Actions to Date*; and an online health care degree completion program offered by MSU-Billings to students with Associate degrees.

Nursing Education Program

Ms. Smith presented a nursing education program offered by Dr. Plantz, an out-of-state physician who uses states' workforce board grants to offer specialty nursing courses. Ms. Stergar observed the physician's program appears to be an online offering, one of many such programs being developed around the country. Continuing education with ties to the university system already exists in Montana. Ms. Lipp Sirota advised Dr. Plantz's letter was included in members' packets as an example of a type of training which may or may not be currently utilized in Montana.

Dental Workforce in Montana Material

Ms. Stergar discussed several issues in the dental workforce:

- As the State Licensing Board considers expanding licensing, the question arises regarding dental clinic ownership.
- There are billing issues for hygienists and assistants who may be doing some work more typical of dentists.
- The state has no medical or dental school. An initiative program is emerging to seek money to support dental students, for example, by partnering with University of Washington.
- Methods of recruiting dentists and creating incentives to keep them in Montana are needed.

Physician Incentives

Linda Hyman, Montana State University's Vice Provost for the Division of Health Sciences, and Director of the Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) Medical Education Program, has been involved with the Montana Rural Physician Incentive Program (MR PIP), which includes an extensive review of shortages, mal-distributions and incentives. Physicians still have other options but are offered partial loan re-payment if they agree to work rurally. A similar program is being discussed for dentists. However, a problem is the existing incentive re-pays up to $45,000 of medical school debt, whereas students are facing $100,000+ debt upon graduation. Ms. Stergar agreed $45,000 is not a very attractive incentive. For example, dental students face $200,000 debt upon graduation. New physicians and dentists are being asked to return home to practice at three-quarters of the salary they can make elsewhere, with only partial loan re-payment. One option is the federally funded National Health Service Core Scholarship, which pays medical school costs in exchange for the students' commitment to practice in under-served areas.

David Gibson, Associate Commissioner for Research, Technology and Communications for the Office of the Commissioner of Higher Education (OCHE) said the University Regents resist payback, the concerns including:

- A possible decline in quality of students with such a “carrot”.
- It will take thousands of physicians if positions will be filled randomly.
- It creates a great deal of uncertainty among medical students regarding their practice location after graduation.

Ms. Hyman added other consequences of payback are:
- Loss of continuity of care for the community.
- Students are driven into non-primary care, because specialties will allow them to pay off their loans without getting involved in other payback programs. Payback makes intuitive sense, but incentives make more sense in practice.

Dr. LeeAnna Muzquiz gave an example from personal experience. As a recipient of an IHS scholarship which she re-paid with service, she witnessed colleagues who were placed, served their time and left. The charge is to find students who commit to Montana and under served areas, regardless of a payback. Ms. Lipp Sirota said that was the best case scenario and asked if paybacks are the best incentives for Montana. Ms. Hyman stated Montana is ranked below many other states in the incentive programs it offers. WWAMI’s approach is to attract students who exhibit characteristics indicating they will return home to practice, for example, their hometown, family income. Ms. Lipp Sirota said they want to be sure that Montana is getting the best bang for its buck on its investments, including the rate of return they get on the money that they put into a program. She appreciates the WWAMI initiatives, including the third-year track to bring back students to Montana communities. Ms. Stergar cautioned the Task Force to not rule out any options. The state needs to include a variety of strategies. WWAMI does not produce enough medical professionals to serve the state. There is no support for dental students. Incentives for non-Montanans and older physicians need to be created, as well. Ms. Palmer asked why WWAMI incentives do not benefit IHS students. Ms. Hyman replied there are too few dollars to stretch, so the state has specific criteria about student placement to be considered for re-payment options. It provides “gap funding” for the period before federal loan repayment begins.

Mr. Gibson stated the incentive program is partly in statute and managed by the university system, but a broader range of policy makers needs to become involved, as they are in other states. Kristin Juliar, Montana State University’s Director of Montana Office of Rural Health, and Director of Area Health Education Centers (AHEC), pointed out other states house such a program in their departments of labor or public health and human services.

Emergency Medical System Shortage

Chair Sullivan moved the Task Force to the end of the information items. Ms. Lipp Sirota presented the *EMS Shortages* hand out as an issue another Task Force is addressing. She learned about that Task Force when she met with the Department of Public Health and Human Services (DPHHS) to update them on the SWIB Health Care Task Force’s work. She had been unaware that volunteer emergency medical professionals are often the only personnel available to address rural medical emergencies. DPHHS also is concerned about the shortage of public health staff in areas around the state. Mr. Mitchell pointed out in Wheatland County, ambulance service is often unavailable.

Clinical Laboratory Science

Ms. Juliar stated the state’s Clinical Laboratory Program has only four students in Great Falls, and it is about to close. Montana is collaborating with North Dakota to get accreditation. The problem is trained students do not return. Ms. Palmer distributed an *MUS Clinical Laboratory Science Training Program* hand out. She said there is an expected national annual average

shortage of 12,000 Clinical Technologists, and only 3,000 to 4,000 are currently being trained. Trained Montana Clinical Lab Scientists do not return to the state. For instance, it took Mr. Mitchell 11 months to recruit a Lab Scientist to Wheatland.

Ms. Palmer believes the MUS Clinical Laboratory Science Training Program fits the Governor's charges to the SWIB and keeps students in Montana. It is three-plus-one years, with $30,000 to 40,000 salary potential upon graduation, and requires graduates to teach students in rural areas. Ms. Hyman said the program is already approved by the Board of Regents. All that is needed is a one time startup cost of one million dollars, for accreditation and equipment. Participating students' tuition and major participating hospitals which conduct the training provide the program money after that. University of Montana and Montana State University-Billings are partners, ensuring no duplication, and hospitals across the state are committing.

Summary

Ms. Smith distributed a *Health care Task Force Data Summary* as a guide for members' afternoon work. Chair Sullivan stated the afternoon would be devoted to narrowing the data areas to recommend to the SWIB Executive Committee to be forwarded to the full Board, which is tentatively scheduled to meet in November 2006.

Task Force Discussion

Ms. Stergar inquired about the sources of the Governor's health policy. Ms. Lipp Sirota replied this is the workforce piece. His policy advisors include Anna Sorrell, Joan Miles and others. Ms. Kelly-Clark pointed out DPHHS is in charge of facility licensing, whereas Department of Labor and Industry (DLI) is responsible for individuals' licensing. Deb Matteucci stated Department of Corrections also has health care workers. Ms. Lipp Sirota said Montana's agencies communicate on a regular basis both on the director level and on the staff level, and the state is now trying to better communicate data, driven by health care issues. Chair Sullivan stated the largest private employers in many Montana communities are hospitals. For instance, reimbursement to critical access hospitals is generating facility re-models and expansions, which bring in jobs.

She mentioned recent newspaper series featuring Montana's nine non-profit hospitals, including what the hospitals charge and their staff salaries. Health care is the economic driver. It cannot be ignored.

Dr. Muzquiz spoke about Native American health care workforce issues. As the Task Force continued working on developing recommendations, Ms. Matteucci suggested leaving in recommendations already suggested by other groups, as validation of a common health care need identified by many, disparate parties.

Ms. Smith presented a flip chart of topics, themes, gaps, concerns. Ms. Stergar suggested presenting information in "WHEREAS" statements:

<u>WHEREAS STATEMENTS</u>
WHEREAS, by 2010, per capita, Montana will have the 4th oldest population in the nation,
WHEREAS the U.S. Census projects eastern MT is losing population and aging,
WHEREAS western Montana is increasing population, and
WHEREAS transportation remains a critical issue for health care delivery in rural areas,

Maps

Members discussed health care mapping that has been done:

- Dr. Eldredge's quotient map indicating ancillaries in greatest need.
- Ms. Stergar pointed out drivers of care, such as doctors and dentists, are needed. The three Health Professional Shortage Areas (HPSA) maps indicate mental health, medical and dental shortages. Mr. Mitchell stated the federal government allows states leeway in unique situations, such as HPSA-designated areas. He said the designation is based on number of primary care physicians per population. In addition, these under-served areas represent large geographic areas.

Ms. Lipp Sirota stated SWIB needs the big picture: the Task Force should identify glaring problems, projected shortages, and make recommendations addressing these. Ms. Palmer suggested creating a combination of specific and general recommendations.

One Problem When Looking at Health care Shortages: Data

Dr. Eldredge's research concluded rural physicians did not earn less in rural than urban counties. Is this due to unavailable data?

- Licensing data are frustrating because they are inaccessible, except for continuing education purposes. Licensees become angry if they feel they are being marketed to.
- Current reporting is voluntary.
- Lack of data specificity, i.e., it is aggregated information. For instance, Ms. Kelly-Clark stated schools need to call students or the respective board to know whether the students have passed their Physician's Assistant or Nursing licensing exam. Mr. Gibson's hospital and clinic data are obtainable because they are aggregated.
- DLI's Research and Analysis Bureau receives federal funding to collect much data, but the feds restrict access, partly to maintain data confidentiality in small communities.
- The Labor Day Report may not contain data indicating a health care workforce shortage, but anecdotes around the state are saying otherwise. The problem is policy will not be set by anecdote.
- Dr. Eldredge's numbers consider the economic impact of private sector health care, not publicly funded programs.
- Data systems and bases are incompatible stand alones.

Remedies for Data Issue

- Mention recommendations already suggested by other health care Task Forces to validate common health care needs.
- Recommend honoring confidentiality but also acknowledging the critical nature of the health care issue and the critical need for related data. Forward a bill or open it up in statute to make available licensing information not just for continuing education but research.
- Viewing health care and education as economic indicators. For instance, the largest private employer in some communities is the hospital.
- Identify the core data needed to create good aggregate data.
- Data need to include items such as:
  - Scope of practice
  - Location of work place
  - Location of home residence
  - Work status: in active practice or retired or other.
  - Any shortage the provider is experiencing.
  - Admission and attrition numbers among health care students

  - Psychiatric Nurses.
  - Other indicators, data points needed to make projections.
  - Samples drawn from public health as well as private health care providers.
- Identify what databases among partners contain these core data.
  - Office of the Commissioner of Higher Education is meeting with the university system, which has access to these data.
  - The DLI Research and Analysis team is working to match data up from different sources.
  - Involve the licensing boards to see what is needed to gain research access to their data.
- Possibility of conducting poll surveys.
- Request the SWIB prompt an annual or semi-annual report.
- Data must be collected over years, to reveal trends.
- Keep the Health care Task Force as a standing committee:
  - to report to the SWIB.
  - to be a resource that providers and the university system can approach.
  - to prompt and track data reporting.
  - to report substantive information to the Legislature.
- Use other studies as models:
  - The State of Montana's Study of the Uninsured: university research staff did not extrapolate from national data but entered the field to collect these data for Montana. Create a study that contacts every hospital, every dentist.
  - Look at other states' efforts, for example, their demand studies.

Training-related Reasons for Shortages

- Montana has limited training program in some medical professions.
- Nursing lacks the capacity to take on many students in some clinical settings. For instance, Montana Tech is experiencing a bottleneck of students needing clinical sites.
- Facility burn out: preceptors train students out of goodwill; they are not paid extra.
- The Nursing Board cannot approve rural programs, which have to compete with the university.
- Few health care apprenticeships are available.

Remedies for Training Shortage

- Possible recommendation to the SWIB to continue to:
  - project and recognize future crises.
  - partner and pool resources with health associations, the university system, Department of Labor and Industry, training programs.
  - support partnerships with WWAMI and University of Washington. Build on existing efforts.
  - Consider other states' training programs as models, for instance, Oregon's computerized management of clinical training.
- Youth do not know what is available. Partners need the staff to go into schools with career counseling, state the opportunities.
  - Include programs with a focus on Native American students.
  - Hospitals hold career days.
  - Northern Montana Hospital, Miles City, goes into the schools to discuss health care opportunities, including two-year degrees such as Radiology Technician.
  - WWAMI and Western Interstate Commission for Higher Education (WICHE) students work with schools as part of their training.

    - In another town, a dentist or doctor goes to school at recess to speak with young students. This is a partnership with the YMCA.
    - Federally funded programs, like AHEC (Area Health Education Center).
- Reach out to the 30- to 45-year-old population segment that have been out of the health care workforce and want to return to it.
    - The Retired Nurses Association is a very good source of workers. (RNA members created Westmont.) Inactive nurses can be found by filtering by "inactive" status in member lists.
- Get the larger hospitals to outreach in small communities where they are affiliated with small hospitals.
- Look at admission and attrition numbers among health care students.
- Offer refresher course for licensees who have left the workforce for any period of time.
- Look at the coursework the university system has and/or needs to create.
- Coordinate with existing aging worker programs, such as those within DPHHS.
- Consider other ways communities can access education locally, for example, through distance or internet learning, for skills training and confidence building.

Lifestyle-related Reasons for Shortages

- Some types of cultural amenities are lacking, for instance, those that do not relate to the outdoors.
- Metropolitan-trained medical personnel may have difficulty adjusting to small rural town life.
- Smaller communities provide less, or a total lack of, collegiality and professional growth.
- There is the stress of being on call 24/7, especially if one has not been trained for emergency or specialty care.
- Health professionals do not enter public health in adequate numbers, especially in environments like prisons.

Remedies for Lifestyle Issues

- Market to various audiences, including high school students at career days.
- The Office of Tourism, Department of Commerce, does not feature eastern Montana as much as it could.

Financial Reasons for Shortages

- Financial incentives are lacking: salaries and benefits are considerably below national market. Health care is unique because 80% of revenue comes from federal funds, and the federal government sets those wages without regard to local prices. The majority of money in health care comes from federally- and insurance-capped sources, like Medicare and Medicaid.
    - A private practice physician's patient population mix drives that physician's income more so than a hospital's income, which has to be more in keeping with market wage to retain its practitioners.
    - Nurses' wages are driven by bargaining unit. The *Mid-Range RN Wages for MNA Bargaining Units* varied by town.
    - Specialty wages may not be below/that much below the market.
    - Small communities cannot compete for grants with large institutions which have grant writers on staff. Seed money is needed.

Remedies for Financial Issues

- SWIB's guiding principle is fiscal responsibility. The Health care Task Force does not need to recommend specific dollar amounts or budget proposals, but will look at methods and ideas as suggested solutions.
- Think outside the box.
- The Task Force can help facilitate rule and policy changes, leverage resources.
- SWIB can advocate with other entities, including the private sector.
- Educate and involve the business community, like small businesses. Identify issues in other arenas that are being addressed that also affect health care, for example, tax incentives.
- Understand the Governor's and Legislature's budgetary constraints.
- Provide the incentives, looking to nursing as a model that has risen to the occasion.
- Use creative staffing and other health care solutions already in place around the state, keeping in mind tax and privacy issues.
    - At White Sulphur Springs Hospital, Katherine Ann Campbell staffs the facility with a Helena physical therapist, whom she lodges and boards for free on days he is at WSSH providing services.
    - The hospital in Wheatland County does not offer staff health benefits but an internally funded annual dollar amount that employees contribute to their own health care and that needs to be used at the hospital.
    - Mr. Mitchell had done something similar while running a hospital network in West Virginia. Businesses in the community paid $30 to $40 per month per employee, and employees paid a $10 co-pay. Montana's Insurance Commissioner is receptive to this concept.
    - The Pharmacy Board has visited with an insurance company regarding an in-house clinic for employees, staffed a few days a week by a physician and a part-time pharmacist.
- Use technology not just for distance training but to fill other health care gaps:
    - Hospitals are willing to stabilize patients in need of mental health services utilizing telemedicine, rather than send them to Warm Springs Hospital. Alaska is doing behavioral health evaluations with telemedicine. Mr. Mitchell reported a HRSA grant has allowed seven people in Wheatland County to sit in a class on diabetes with the Billings Clinic.
    - Mr. Mitchell reported on an innovative pharmacy plan. Wheatland has no pharmacist to fill prescriptions locally. Residents have had only two options: drive 45 miles to a Big Timber pharmacy or mail order their prescriptions. Mr. Mitchell has worked with St. Vincent's in Billings to install a medicine vending machine and have a local pharmacy technician send scripts electronically to Billings, which are then returned and filled. The pharmacy plan includes video phone patient counseling with the Billings pharmacist. Fifteen scripts a day are filled this way. Mr. Mitchell's grant came from BEAR two-and-a-half years ago is almost breaking even this year.
    - Mr. Mitchell mentioned a $10,000 radiology digitalizer that allows test results to be returned within minutes, an aide to primary care physicians.
- As always, lobby for Medicare reimbursement rates. Medicare standards then are met by private insurers.
- Refer to towns as "frontier" when applying for funding.
- Offer hospitals and physicians' offices tax incentives to be clinical sites.
- Work with banks on offering low home loan rates.
- Lobby to give health care organizations, like sole community hospitals, immunity from inurement, so that these communities are able to attract key staff.
- Target financial incentives in difficult-to-staff environments, such as reservations, prisons, mental health.

Population Pockets where Shortages are Intensified

Native Americans

- Reservations are experiencing the same primary care, dental and lab technician shortages as those found elsewhere in the state but are more pronounced.
- Some shortage areas where Natives reside are saturated with private physicians, but these are not meeting the need.
- IHS's federal funding does not meet the people's needs.
- If IHS experiences budget cuts and Native Americans enter urban environments, they may be represented in the DOC population.

Department of Corrections (DOC) Clients

- Public health and corrections systems need to better align services for their shared clients.
- No continuity of care exists for clients re-entering the community. Redundant assessments and new treatment plans are created.
- Currently, there is no treatment modality.
- Recruitment of mental health providers to the state prison is difficult.
- The prison provides the same health care as the community but with state general funds and no support from Medicaid. Community care is subsidized by federal dollars.
- Inmates lose the gainful employment to reimburse their own health care costs.
- Geographical isolation, limited finances, and insufficient numbers of providers are forces driving clients to prison health care.
- If IHS experiences budgets cuts and Native Americans enter urban environments, they may be represented in the DOC population.

Remedies for Population Pockets

The Task Force must consider the applications or impacts of its general recommendations to more specific areas, like reservations.

Native Americans

- Native Americans are citizens of the state; the same remedies apply to the reservations, for example, physician incentives.
- Coordination should come from the IHS Area Office in Billings.
- Partners who enter schools to do health care career counseling, state the opportunities, should include focus on Native American students.
- Partner with the tribes, not assuming federal funds alone will take care of this population.
- Consider how any incentive impacts tribes and reservations.
- Partner with the tribes on scholarships.
- Target financial incentives on reservations.

DOC Clients

- Deb Matteucci recently has become the DOC-DPHHS liaison for inmates needing mental health and chemical dependency services.
- Target financial incentives in prisons, especially incentives for mental health professionals.

Next Steps

Ms. Smith stated she will compile the 11 pages of flip chart notes into draft recommendations to send to the Task Force for review. Members are welcome to email back comments. Ms. Smith said she expects to have a draft ready for the Task Force by September 29th . The HCTF Report

and previous minutes will be approved at a conference call to be scheduled at a later date. Ms. Stergar requested the Task Force have a week to respond.

Next Meeting
The exact date for the conference call was not scheduled.

Adjournment
Having no further business, the meeting was adjourned at 4:00 p.m.